THE TEXAS HEART INSTITUTE®
CENTER FOR CARDIOVASCULAR CARE
6624 Fannin, Suite 2600 • Houston, Texas 77030 • (713) 790-9401

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS AND PRIMARY CARE PHYSICIANS

You have reviewed and signed the Notice of Privacy Practices that describes how we disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

NOTE: You have the right to request a restriction of your protected health information at any time. However, patients may request we communicate their protected health information to spouses, relatives or friends. Examples are communicating appointment times, pre-procedure instructions, relaying test results, relaying medication instructions, communicating physician's orders and other such protected health information to someone besides you. If you request this right, we are required to have a completed authorization on file **prior** to releasing your protected health information. If you wish for someone to have access to your protected health information please complete the authorization below.

The protected health information covered by this authorization includes communicating over the telephone the following: (**Please initial by each protected health information you wish to be disclosed**)

_____ Appointment Times and Instructions _____ Questions Regarding Current Health Status _____ Test Results

_____ Physician Orders _____ Pre-Procedure Instructions _____ Medication Questions or Changes

I authorize the individuals below access to my protected health information over the telephone. This authorization is effective until such time as you revoke or terminate this authorization.

_____ _____
Name Relation

_____ _____
Name Relation

You also have the right to request to receive confidential communications from us by alternative means other than speaking with you over the phone. An example is by answering machine, voice mail, fax machine or email. These means may or may not be secure if others have access to them. If you request this right, we are required to have a completed authorization on file prior to releasing your information.

The protected health information covered by this authorization includes communicating via the follow means and will remain in effect until such time as you revoke or terminate this authorization. (**Please initial by each method you wish our practice to communicate with you**)

_____ Answering Machine at Home _____ Voice Mail on Cell Phone _____ Voice Mail at Work _____ Email

If you would like our office to communicate your protected health information to your primary care physician or referring physician, please indicate their name and address:

Name of Physician: _____

Address of Physician: _____

Signature below is only acknowledgement that you have read and understand the implication of this authorization to release your protected health information to others designated above, to your referring physician and/or communicate by alternative means.

_____ _____ _____
(**PRINT NAME**) (**SIGNATURE**) (**DATE**)

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REVOCATION OF AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The Privacy Laws outline your right to revoke or terminate the authorization to use and disclose protected health information at any time.

This notice revokes the authorization to the use and disclosure of protected health information to the following individuals:

_____	_____
Name	Relation
_____	_____
Name	Relation

The original consent was signed on:

_____
Date of Original Authorization

EFFECT OF REVOCATION

Protected health information that is collected on or after the date on which this form is received will not be used or disclosed by our practice for any purposes not related to treatment, payment or health care operations as outlined in the signed Notice of Privacy Practices.

The effective date of the revocation of authorization to use or disclose protected health information is _____.

Signature below is only acknowledgement that you have read and understand the implication of this authorization to release your protected health information to others designated above, to your referring physician and/or communicate by alternative means.

_____	_____	_____
(PRINT NAME)	**(SIGNATURE)**	**(DATE)**